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Invited Commentary

Realist thoughts on Cinderella, Alice in Wonderland and health care interventions

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One of the achievements of realist methodology has been to change the basic question posed in evaluative inquiry. No longer is it sufficient to ask whether a particular care intervention or treatment 'works'. Attention instead switches to explanatory mechanisms – what is it about the intervention which produces change? Inquiry thus begins with a 'program theory', the ideas that drive and inspire the programme. Empirical inquiry then takes on the task of testing and refining that theory. And, if all has gone well, the virtuous circle is completed with an improved understanding of benefits and beneficiaries that can be then returned to policy and practice (Pawson and Sridharan 2009).

This change of emphasis has great potential for disciplines like nursing in which the 'intervention' is subject to variation from patient to patient, distributed across many hands, played out in conjunction with other treatments and care, conducted under different philosophies and managed under regimes that seek to foster continuous self-scrutiny and improvements in organizational performance. For all these reasons it is often hard to put one's finger on what nursing is or does and from the point of view of the so-called 'hierarchy of evidence', such heterogeneity has rendered much nursing inquiry a Cinderella – unable to prove its worth through the supposed gold-standard randomized trials and thus shunned by the Ugly Siblings that preside in many academic and professional settings.

Thanks in part to realist thinking, there is now much closer examination of how health interventions work and the significance of their processual nature, thus highlighting the progressive and consolidated release of one care mechanism after another. Two landmark inquiries, evoking two further characters from children's fiction, are sufficient to tell the tale.

For our first exhibit, we turn to the curious episode of the 'Dodo's Verdict'. Alice, during her adventures in Wonderland, comes across a bizarre competition officiated by a dodo bird. It is a simple enough contest, a race around a lake. She is bemused, however, because apparently no one bothers to measure times, distances, placements and so on. Instead, the dodo decrees: ''Everybody has won and all must have prizes''.

This same unflattering verdict has been bestowed on psychotherapy. There are many, many different therapeutic schools. One count, made 40 years ago (Parloff 1986), estimated the number at 418. A thunderous and longstanding critique argues that the specific techniques associated with specific schools (e.g. Freudian, Jungian, Rogerian, Adlerian, behavioural, cognitive, gestalt, existential, etc.) serve very limited purpose and that most of the positive effect is gained due to therapeutic *relationship*. This hypothesis known as 'common factor theory' associates positive change with 'non-specifics' emanating from purposeful, warm, respectful, tailor-made, one-to-one relationships between practitioner and client.

Psychotherapy has always been a hot topic for evaluation. As these inquiries grew, they evolved a comparative component in which the efficacy of rival or alternative treatments was investigated. These are known as 'active treatment comparisons'. Instead of randomly placing patients in treatment and control conditions, they are assigned to one of two treatments (e.g. cognitive versus behavioural). This ensures 'fair' comparison on a matched population. And as these studies gathered pace it became possible to conduct meta-analyses of the efficacy of 'x versus y'. Systematic reviews of this ilk by Luborsky, Singer, and Luborsky (1975), and repeated in Luborsky et al. (2002) with a much larger sample of primary studies, came down heavily in favour of the dodo bird verdict. Very few primary studies demonstrated the superiority of one treatment over another. In the round, the meta-analysis estimates that the effect size attributable to specific therapy techniques weighs in with a Cohen's *d* coefficient of only 0.2 (small and insignificant in lay parlance).

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By this interpretation all therapies are more or less equal – and almost all should win prizes (or perhaps be amalgamated, simplified and demystified!). Whilst debate continues to rumble about the powers of discernment of such meta-analytic estimates (Chambliss 2002), few deny the significance of the 'non-specifics'.

One of the step changes in modern health care is the emphasis now placed on 'concordance', 'teachable moments' and 'shared decision-making' between practitioners and patients. Our second case study is provided by a noteworthy investigation of one such interaction in a trial by Pollo et al. (2001) on recovering patients following cancer surgery. It is significant because it investigates the most basic encounter, namely informing the patient what their medication is and does.

The subjects in the trial, following normal practice, were given analgesics shortly after surgery and then at intervals over 3 days. In addition, they were put on an intravenous drip (IV) containing only a saline solution. This acted as the placebo in the experiment. Group 1 were told nothing about the contents or purpose of the IV. Group 2 confronted the classic blinding routine of being told that the IV was *either* a further real analgesic or a placebo. Group 3 was told that the IV contained a further pain killer.

The outcomes of these different regimes were measured by charting requests for additional pain killers. These were real patients in real recovery and it was normal practice for them to be able to 'top-up' the standard dosages, if they wished to do so. Group 3 requested 34% less analgesics than group 1 and 16% less than group 2. This, of course, is one experiment on one portion of a treatment in a highly specific locality for a highly specific condition. But it does begin to show the power of 'mere' verbal instructions and it does reveal the importance of those actors whose task it is to communicate, to conciliate, to counsel and to console.

So, back to the point. Much that is efficacious about nursing (and indeed also medicine and healthcare interventions of other disciplines) is non-specific, tacit, submerged, routine and taken-for-granted. The way forward for nursing is in inquiry that begins with the summons to find out *what it is, whatever it is* that makes for good practice.

As readers are about to discover in this special edition of Nursing Inquiry, realism and critical realism come in many varieties. What all approaches share is an explanatory quest, starting with theories of why health outcomes turn out as they do and putting those theories to close and robust scrutiny. Angus and Clark are to be congratulated on guest co-editing such an innovative and timely edition.

As the old saying goes – ''innovation is the ability to see change as an opportunity and not a threat''.

Ray Pawson
Professor of Social Research Methodology
University of Leeds, Woodhouse Lane, Leeds LS2 9JT, UK
E-mail: r.d.pawson@leeds.ac.uk

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